ARKANSAS DEPARTMENT OF FINANCE AND ADMINISTRATION
REQUEST FOR LEAVE WITHOUT PAY

SECTION A: *To be completed by Employee*

NAME _____ SOC SEC NO _____

OFFICE _____ POSITION NO _____

LWOP BEGINNING DATE _____ LWOP ENDING DATE _____

REASON FOR REQUEST: _____

_____

SIGNATURE _____ DATE _____

NOTE: During periods of LWOP it is the responsibility of the employee to pay the total cost of his/her State Employees Group Health and Life Insurance, to include the State's matching portion. When approved for LWOP, a payment schedule will be provided. Failure to comply with the due dates and premium amounts reflected on that schedule will mean **immediate cancellation** of the Group Health and Life Insurance.

SECTION B: *To be completed by the Supervisor*

NAME _____ TITLE _____

APPROVAL: YES [ ] NO [ ]

SIGNATURE _____ DATE _____

SECTION C: *To be completed by Manager*

NAME _____ TITLE _____

APPROVAL: YES [ ] NO [ ]

SIGNATURE _____ DATE _____

SECTION D: *To be completed by Administrator*

NAME _____ TITLE _____

APPROVAL: YES [ ] NO [ ]

SIGNATURE _____ DATE _____